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IN THE SUPREME COURT OF THE UNITED STATES
October Term, 1990

THE COLORADO DEPARTMENT OF SOCIAL SERVICES,
Petitioner,
vs.
UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; LOUIS W. SULLIVAN, M.D.; NORVAL SETTLE; ALEXANDER TEITZ; and JUDITH BALLARD, in official capacities,
Respondents.

PETITION FOR WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE TENTH CIRCUIT

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QUESTION PRESENTED FOR REVIEW

Whether the Department of Health and Human Services impermissibly has narrowed the "good faith and due diligence" exception (42 U.S.C. § 1396b(g)(4)(B) (1985)) to the State's responsibility to annually inspect the care given to residents in nursing homes participating in Medicaid, by adding a requirement that any failure to inspect must be due to events beyond the State's control.

The Colorado Department of Social Services ("the State," "Colorado" or "CDSS"), Appellee below, hereby petitions this Court for a writ of certiorari to review the judgment in this matter of the United States of Appeals for the Tenth Circuit, which is in conflict with the decision of the United States Court of Appeals for the Third Circuit in *Commonwealth of Pennsylvania, Department of Public Welfare v. United States Department of Health and Human Services*, 928 F.2d 1378 (3d Cir. 1991).

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OPINIONS BELOW

The opinion of the United States Court of Appeals for the Tenth Circuit, dated March 22, 1991, is reported at 928 F.2d 961 (10th Cir. 1991), and is set forth in Appendix A. The Order of the United States District Court for the District of Colorado dated September 21, 1989, from which the appeal was taken, is not reported but is set forth in Appendix B. A transcript of the oral order of the District Court is set forth in Appendix C. The Decision of the Departmental Appeals Board ("Board") of the United States Department of Health and Human Services ("HHS") dated March 15, 1989, the final agency action

of which judicial review was sought, is set forth in Appendix D.

JURISDICTION

The jurisdiction of this Court to issue a writ of certiorari in this case is invoked pursuant to 28 U.S.C. § 1254(1) (1988).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

42 U.S.C. § 1396a(a)(31) (1985) provides in relevant part:

> [A State plan for medical assistance must--]
>
> with respect to skilled nursing facility services (and with respect to intermediate care facility services, where the State plan includes medical assistance for such services) provide--
>
> ....
>
> (B) with respect to each skilled nursing or intermediate care facility within the State, for periodic onsite inspections of the care being provided to each person receiving medical assistance, by one or more independent professional review teams (composed of a physician or registered nurse and other appropriate health and social service personnel), including with respect to each such person (i) the adequacy of the services available to meet his current health needs and promote his maximum physical well-being, (ii) the necessity and

desirability of his continued placement in the facility, and (iii) the feasibility of meeting his health care needs through alternative institutional or noninstitutional services;

42 U.S.C. § 1396b(g)(1) (1985) provides in relevant part:

> [T]he Federal medical assistance percentage shall be decreased as follows: After an individual has received inpatient hospital services or intermediate care facility services for 60 days, skilled nursing facility services for 30 days, or inpatient mental hospital services for 90 days (whether or not such days are consecutive), during any fiscal year, the Federal medical assistance percentage with respect to amounts paid for any such care furnished thereafter to such individual shall be decreased by a per centum thereof (determined under paragraph (5)) unless the State agency responsible for the administration of the plan makes a showing satisfactory to the Secretary [of HHS] that, with respect to each calendar quarter for which the State submits a request for payment, ... such State has an effective program of medical review of the care of patients in mental hospitals, skilled nursing facilities, and intermediate care facilities pursuant to paragraphs (26) and (31) of section 1902(a) [42 U.S.C. § 1396a(a)(26), (31)], whereby the professional management of each case is reviewed and evaluated at least annually by professional review teams.

42 U.S.C. § 1396b(g)(4)(B) (1985) provides:

> The Secretary shall find a showing of a State, with respect to a calendar quarter under paragraph (1), to be satisfactory under such paragraph with respect to the requirement that the State conduct annual onsite inspections in mental hospitals, skilled nursing facilities, and intermediate care facilities under paragraphs (26) and (31) of section 1902(a) [42 U.S.C. §§ 1396a(a)(26), (31)], if the showing demonstrates that the State has conducted such an onsite inspection during the 12-month period ending on the last date of the calendar quarter --
> (i) in each of not less than 98 per centum of the number of such hospitals and facilities requiring such inspection, and
> (ii) in every hospital or facility which has 200 or more beds,
> and that, with respect to such hospitals and facilities not inspected within such period, the State has exercised good faith and due diligence in attempting to conduct such inspection, or if the State demonstrates to the satisfaction of the Secretary that it would have made such a showing but for failings of a technical nature only.

42 C.F.R. §456.652 (1988) provides, in relevant part:

> (a) General requirements. In order to avoid a reduction in FFP, the Medicaid agency must make a satisfactory showing to the Administrator, in each quarter, that it has met the following requirements for each recipient:

....

(4) A regular program of reviews, including medical evaluations, and annual on-site reviews of the care of each recipient....

(b) Annual on-site review requirements.

(1) An agency meets the quarterly on-site review requirements of paragraph (a)(4) of this section for a quarter if it completes on-site review of each recipient in every facility in the State, and in every State-owned facility regardless of location, by the end of the quarter in which a review is required under paragraph (b)(2) of this section.

42 C.F.R. § 456.653 (1988) provides:

The Administrator [of the Health Care Financing Administration] will find an agency's showing satisfactory, even if it failed to meet the annual review requirements of 456.652(a)(4), if

a) The agency demonstrates that --

(1) It completed reviews by the end of the quarter in at least 98 percent of all facilities requiring review by the end of the quarter;

(2) It completed reviews by the end of the quarter in all facilities with 200 or more certified Medicaid beds requiring review by the end of the quarter; and

(3) With respect to all unreviewed facilities, the agency exercised good faith and due diligence by attempting to review those facilities and would have succeeded but for events beyond its control which it could not have reasonably anticipated;

or

(b) The agency demonstrates that it failed to meet the standard in paragraph (a)(1) and (2) of this section of the close of the quarter for technical reasons, but met the standard within 30 days after the close of the quarter. Technical reasons are circumstances within the agency's control.

STATEMENT OF THE CASE

A. Factual Background

Under the Medicaid program established by Title XIX of the Social Security Act, the Health Care Financing Administration ("HCFA") provides federal financial participation ("FFP") to participating States, provided that they comply with a myriad of complex requirements. One of these requirements is to submit quarterly reports demonstrating that the State "has an effective program of medical review of the care of patients" in long-term care facilities. 42 U.S.C. § 1396b(g)(1) (1985). HCFA has interpreted this statute to require the State to review every Medicaid patient.

Congress, however, tempered the statutory medical review requirement by enacting 42 U.S.C. § 1396b(g)(4)(B) (1985), which provides that the State will receive its full share of FFP if the State inspects all of the facilities with 200 or more beds and at least 98% of all facilities, provided that the State "has exercised good faith and due diligence in attempting to conduct" the inspections, or would have inspected all the facilities "but for failures of a technical nature only." In its regulations found at 42 C.F.R. § 456.653 (1988), HHS restricted the statutory exceptions by requiring not only "good

faith and due diligence" but also "events beyond the control of" the State "which it could not have reasonably anticipated." 42 C.F.R. § 456.653(a)(3).

Utilizing the same procedure which had been in place since utilization control inspections were initiated in 1981, Colorado inspected a nursing home known as Spring Creek Health Care Center in March of 1988, relying on the nursing home's census to determine which patients in the facility were eligible for Medicaid, and therefore subject to review. Colorado had never experienced any prior disallowance for any failure to inspect patients using that procedure. However, in May of 1988, because Spring Creek Health Care Center failed to identify three Medicaid patients to the State, HCFA found that Colorado did not review the care of these patients. The Secretary refused to excuse Colorado's failure under the "good faith and due diligence" exception, and assessed a disallowance against Colorado of $89,428.95, as though Spring Creek Health Care Center had not been inspected at all.

B. Procedural Background

On September 22, 1988, CDSS received notice from HCFA of the disallowance of FFP. CDSS appealed the disallowance to the Board on October 25, 1988. The disallowance was affirmed by the Board on March 15, 1989.

Upon judicial review on September 21, 1989, the United States District Court for the District of Colorado found, in accordance with the reasoning of the court in *Delaware Division of Health and Human Services v. United States Department of Health and Human Services*, 665 F. Supp. 1104 (D. Del. 1987), that the subject regulations of HHS are unreasonable and remanded the case to the Secretary for the return of the

$89,428.95 disallowance to Colorado. On March 22, 1991, the United States Court of Appeals, Tenth Circuit, reversed the District Court's judgment.

REASONS WHY THE PETITION FOR CERTIORARI SHOULD BE GRANTED

A. To resolve the conflict between the circuit courts.

The United States Court of Appeals for the Tenth Circuit held, in deference to the agency, that HCFA's regulations implementing the statutory exceptions to the reduction of FFP for a State's failure to perform satisfactory utilization control inspections are authorized by 42 U.S.C. § 1396b(g). Only five days later, the United States Court of Appeals for the Third Circuit, in *Commonwealth of Pennsylvania, Department of Public Welfare v. United States Department of Health and Human Services*, 928 F.2d 1378 (3d Cir. 1991), concluded that "the Secretary's inclusion of the 'beyond the control' condition into 'good faith and due diligence' is not supported by the statute" and remanded the District Court's decision which had found the regulations applicable. Furthermore, the United States District Court for the District of Delaware, in *Delaware Division of Health and Social Services v. United States Department of Health and Human Services*, *supra*, which was not appealed and was cited by this court with approval (on a different issue) in *Bowen v. Massachusetts*, 487 U.S. 879, 908 n.46 (1988), found that the regulations at issue here are unreasonable, arbitrary and capricious. The decisions rendered on this issue by lower courts squarely conflict and the issue should be resolved by this Court.

B. To decide an important question of federal law.

This issue has been raised by many States before the Board, as HCFA repeatedly has taken large disallowances for "missing" a minuscule number of patients in a single nursing home due to the facility's error in supplying accurate information to determine which patients are receiving Medicaid benefits. Because the facility itself remains the best source of patient information and due to the virtual impossibility of creating any other system which would identify every Medicaid patient at any point in time, such disallowances will continue if the regulations are allowed to stand.[1] These disallowances have proved to be a windfall for the Federal government. Transparently contrived merely by the unauthorized addition of an unreasonably restrictive standard, "events beyond the control of the State which could not reasonably have been anticipated," the regulations frustrate the more generous standard which Congress intended, that the States may be excused from perfect performance of the inspections within certain parameters, if they made an honest, good faith attempt to do so.

By its interpretation of the good faith and due diligence exception, HHS has virtually eliminated the exception. HHS may not agree with Congress that exceptions should be made based on the States' intention to perform the required

---

[1]Intermediate care facilities and skilled nursing facilities were deleted from the 100 percent utilization review requirements by amendments to 42 U.S.C. § 1396(a), effective after October 1, 1990, when the State has initiated the use of an appropriate resident assessment instrument using a sampling technique (Act of Dec. 22, 1987, Pub. L. No. 100-203, 1988 U.S. Code Cong. & Admin. News (101 Stat.) 1330-212, 213, applicable as provided by § 4214 of such Act). However, intermediate care facilities for the mentally retarded and mental hospitals remain fully subject to 100 percent review inspections. Accordingly, although the Spring Creek Health Care Center operations may no longer be subject to the regulations at issue here, those regulations will continue to affect CDSS' reimbursement.

inspections. However, an agency is not free to legislate but is bound by those powers granted by Congress. *Ernst & Ernst v. Hochfelder*, 425 U.S. 185 (1976). Even a contemporaneous, longstanding agency interpretation must fail if it conflicts with the plain language of the statute. *Public Employees Retirement System of Ohio v. Betts*, 492 U.S. 158 (1989), *on remand*, *Betts v. Hamilton Board of Mental Retardation and Developmental Disabilities*, 897 F.2d 1380 (6th Cir.), *reh'g denied*, 111 S. Ct. 397, 112 L. Ed. 2d 407 (1990). If the ordinary meaning of the words of the statute is assumed in accordance with *American Tobacco Co. v. Patterson*, 456 U.S. 63 (1982), such disallowances and the regulations upon which they are based must fall as they are actions taken beyond the agency's authority.

CONCLUSION

The United States Court of Appeals for the Third Circuit correctly analyzed the law and held that the subject regulations are unreasonable. The Court of Appeals for the Tenth Circuit in the instant case gave undue deference to the agency and disregarded the will and intent of the Congress. The petition for a writ of certiorari should be granted to reverse the judgment of the Court of Appeals for the Tenth Circuit, to establish the correct interpretation of the statute, to resolve the conflict among the various jurisdictions and to end the continued unfair and unwarranted disallowances of federal funds against the states.

Respectfully submitted,

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APPENDIX A

PUBLISH

UNITED STATES COURT OF APPEALS

TENTH CIRCUIT

COLORADO DEPARTMENT OF SOCIAL SERVICES,

Plaintiff-Appellee,

v. No. 89-1353

DEPARTMENT OF HEALTH & HUMAN SERVICES, LOUIS W. SULLIVAN, M.D., NORVAL SETTLE, ALEXANDER TEITZ, and JUDITH BALLARD, in official capacities,

Defendants-Appellants.

APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO
(D.C. No. 89-Z-694)

Joyce K. Herr (Duane L. Woodard, Attorney General of Colorado; Charles B. Howe, Deputy Attorney General; and Richard H. Forman, Solicitor General, with her on the brief), Assistant Attorney General, Denver, Colorado, for the Plaintiff-Appellee.

Patricia L. Bossert (Michael J. Norton, United States Attorney; Stuart M. Gerson, Assistant Attorney General; Ronald S. Luedemann, Chief Counsel, and Jay A. Swope, Associate Chief Counsel, Region VIII, Office of the General Counsel Department of Health and Human services; with her on the brief), Special Attorney to the United States Attorney General, for the Defendants-Appellants.

Before HOLLAWAY, Chief Judge, BARRETT and TACHA, Circuit Judges.

TASHA, Circuit Judge.

Defendant-appellant Louis W. Sullivan, Secretary of the United States Department of Health and Human Services (Secretary), appeals the district court's reversal of a decision of the Departmental Appeals Board (DAB). The DAB upheld the Secretary's penalty of $89,428.95 against plaintiff-appellee, Colorado Department of Social Services (CDSS), for its failure to conduct required inspections to review the care received by Colorado Medicaid recipients. The Secretary argues the statutory penalty should be reinstated because CDSS failed to comply with the valid regulation implementing the statute that requires participating states to review annually the care received by Medicaid recipients. CDSS contends the district court properly disallowed the penalty because this regulation is unreasonable. We reverse.

I. Background

A. Utilization Control Inspections

The Medicaid program was established by Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 *et seq.* (Act). Under this program, the federal government provides financial assistance to participating states that reimburse individuals and facilities for health care provided to qualified Medicaid recipients. To receive these funds, a state must submit quarterly reports demonstrating the state "has an effective program of medical review of the care of patients in mental hospitals, skilled nursing facilities, and intermediate care facilities . . . whereby the professional management of each case is reviewed and evaluated at least annually by independent professional review teams." 42 U.S.C. § 1396b(g)(1); *see also* 42 U.S.C.§§ 1396a(a)(26),(30),(31). These reviews are referred to as "utilization control" inspections. *See State of Wisconsin, Dep't of Health & Soc. Servs. v. Bowen*, 797 F.2d 391, 393 (7th Cir. 1986), *cert. denied*, 485 U.S. 1017 (1988).

A state failing to inspect all eligible facilities within its borders providing care to Medicaid recipients is subject to reductions in federal payments. 42 U.S.C. § 1396b(g)(5). These penalties are calculated as a percentage of the payment for the quarter in which the failure occurred. *Id.*

Penalties will not be imposed, however, if the state has inspected 100% of all eligible facilities with 200 or more beds and not less than 98% of all eligible facilities if one of two conditions is present. First, the Secretary cannot penalize the state if it "has exercised good faith and due diligence in attempting to conduct" the required inspections. *See* 42 U.S.C. § 1396b(g)(4)(B). Second, the state will not be penalized if it "demonstrates to the satisfaction of the Secretary that it would have [inspected 100% of all eligible facilities] but for failings of a technical nature only." *Id.*

The Secretary's regulation implementing section 1396b(g)(4)(B) is found at 42 C.F.R.§456.653. This regulation explains a state has exercised "good faith and due diligence" and thus will not be subject to a penalty if the state "would have succeeded [in inspecting 100% of all facilities] but for events beyond its control which it could not have reasonably anticipated." 42 C.F.R.§456.653(a)(3).[2]

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[2]Section 456.653 allows a state to avoid a penalty under the "failings of a technical nature" exception only if the failure to complete the inspections resulted from circumstances within the state's control. 42 C.F.R.§456.653(b). This regulation also provides that a state may qualify for this exception only if it corrects any technical failings within thirty days of the close of the quarter. *Id.*

B. The Instant Case

The Secretary periodically conducts surveys to ensure states are properly performing utilization control inspections. 42 U.S.C.§1396(g)(2). In May 1988, a federal survey found CDSS had failed to review the care provided to three Medicaid recipients at the Spring Creek Health Care Center in Fort Collins, Colorado. CDSS had relied on the Center's census of Medicaid recipients, which did not list these three individuals, in conducting an inspection of the facility. The Secretary notified CDSS of these errors on June 8, 1988. CDSS concedes it did not review these patients until June 10, 1988. On September 19, 1988, the Secretary notified CDSS of its failure to perform satisfactory utilization control inspections for the quarter ending March 31, 1988. The Secretary assessed a statutory penalty of $89,428.95 against CDSS.

CDSS appealed the penalty to the DAB, arguing it had met the requirements of the statutory "good faith and due diligence" exception and therefore should not have been penalized. CDSS asserted the regulatory interpretation of this exception is invalid because the Secretary exceeded his authority by defining a failure to inspect despite the state's "good faith and due diligence" as a failure due to circumstances beyond the state's control. The DAB disagreed with CDSS, holding the regulation constituted a reasonable interpretation of the statute.

CDSS appealed the DAB ruling to the district court. Both parties filed motions for summary judgment. The district court granted CDSS's motion for summary judgment and reversed the DAB ruling, adopting the reasoning of the court in *Delaware Div. of Health & Social Servs. v. United States Dept of Health & Human Servs.*, 665 F. Supp. 1104 (D. Del. 1987). The district court held the statutory "good faith and due diligence" exception is a subjective standard. The court concluded the regulatory interpretation is invalid because it constitutes an

unduly restrictive objective standard. The court found CDSS's reliance on the Center's census of its Medicaid recipients met the supposedly subjective statutory standard and therefore vacated the penalty imposed by the Secretary.

On appeal, the Secretary contends the district court erred in rejecting his motion for summary judgment and granting judgment in favor of CDSS. He asserts the regulation implementing the "good faith and due diligence" exception is a reasonable interpretation of the statute entitled to deference. CDSS maintains that failure to review one recipient cannot equate with failure to inspect the facility caring for that recipient. CDSS further argues the regulation implementing the "good faith and due diligence" exception is invalid as a contradiction of the plain meaning of the statute.

II. Failure to Inspect a Facility

We first address the question whether failure to review one recipient in a facility constitutes failure to inspect that facility for purposes of the statutory penalty. Where, as here, Congress clearly has expressed its meaning, we must adopt that expressed intent. *See Chevron. U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-43 (1984).

Because the statute defines an inspection to include the review of care received by each Medicaid recipient, a failure to review one recipient in a facility constitutes a failure to inspect that facility. In 42 U.S.C. §1396a(a)(26) and (31), Congress requires states participating in the Medicaid program to perform annual "on-site inspections" of facilities to assess the care provided to *each* Medicaid recipient. Congress subjects states to penalties for failure to perform inspections "pursuant to paragraphs 1396a(a)(26) and (31) of this title . . . ." 42 U.S.C.§1396b(g)(1). Given the penalty provision's explicit cross-reference to the definition of an inspection as requiring

review of each recipient, we find a failure to review a single recipient constitutes a failure to inspect a facility for purposes of the penalty provision. *Cf. K Mart Corp. v. Cartier Inc.*, 486 U.S. 281, 291 (1988) ("In ascertaining the plain meaning of the statute, the court must look to the particular statutory language at issue, as well as the language and design of the statute as a whole."); *Atlantic Cleaners & Dyers, Inc. v. United States*, 286 U.S. 427, 433 (1932) (noting presumption that "identical words used in different parts of the same act are intended to have the same meaning").

CDSS's admitted failure to review three recipients at the Center therefore represents a failure to inspect that facility. CDSS is subject to the statutory penalty unless it qualifies for the exception in 42 U.S.C.§1396b(g)(4)(B). Because CDSS met the statutory exception's initial two requirements of inspecting at least 98% percent of all facilities with fewer than 200 beds and all of the facilities with 200 or more beds, we must determine the proper definition of the exception's third requirement of exercising "good faith and due diligence" in attempting to inspect the Center.[3] *See* 42 U.S.C. §1396b(g)(4)(B).

III Good Faith and Due Diligence

To determine whether the regulation implementing the "good faith and due diligence" exception is valid, we first must determine "whether Congress has directly spoken" to the meaning of this phrase. *Chevron*, 467 U.S. 837, 842. Our review of the statutory language and the legislative history of

---

[3]CDSS concedes it has not satisfied the "technical failings" exception of 42 U.S.C.§1396b(g)(4)(B) and 42 C.F.R.§456.653(b). We do not address the validity of the regulation implementing this statutory provision.

the Social Security Act convinces us Congress did not address this issue.[4]

Rather, by its use of the phrase "good faith and due diligence," a context-specific standard, Congress implicitly delegated to the Secretary the determination of how "good faith and due diligence" should be measured. *Cf. Estate of Smith v. Heckler*, 747 F.2d 583, 587 (lOth Cir. 1984) ("Congress gave the Secretary a general mandate to promulgate rules and regulations necessary to the efficient administration of the functions with which the Secretary is charged by the Act."); *see also* 42 U.S.C. §1396b(g)(1) (state must make a showing "*satisfactory to the Secretary*" that it has reviewed the care received by each recipient) (emphasis added).

Because Congress's intent in requiring "good faith and due diligence" is ambiguous, we must determine whether the Secretary's interpretation in 42 C.F.R. §456.653(a)(3) is reasonable. When "the legislative delegation to an agency on a particular question is implicit . . . . a court may not substitute

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[4]Relying on the decision in *Delaware Div. of Health & Social Servs. v. United States Dep't of Health & Human Servs.*, 665 F. Supp. 1104 (D. Del. 1986), *cert. denied*, 485 U.S. 1017 (1988), the district court concluded Congress has directly spoken on this issue. The *Delaware* court cited a Conferees' agreement on the 1977 Social Security Act Amendments that stated: "'If a facility is not reviewed, there will be a reduction in matching unless the Secretary finds there was a good faith attempt to review the institution, and there is no evidence that any institution . . . is deliberately not reviewed.'" 665 F. Supp. at 1120 (emphasis of *Delaware* court omitted) (quoting H.R. Rep. No. 95-673, 95th Cong., 1st Sess. 48 (1977), *reprinted in* 1977 U.S. Code Cong. & Admin. News 3039, 3122). The *Delaware* court held this passage indicates "the legislature plainly directed the Secretary to employ a subjective standard that focused on the State's good faith." 665 F. Supp. at 1124. We do not believe this fragment of legislative history conveys Congress's clear intent that "good faith and due diligence" be judged by a subjective standard. We therefore must defer to the Secretary's interpretation of the statutory provision.

its own construction of a statutory provision for a reasonable interpretation made by the administrator of an agency." *Chevron*, 467 U.S. at 844; *see also K Mart*, 486 U.S. at 291 ("If the agency regulation is not in conflict with the plain language of the statute, a reviewing court must give deference to the agency's interpretation of the statute.").

The Act repeatedly expresses the goal that states annually review the care received by *each* Medicaid recipient. We cannot say the regulation's requirement that a state do everything within its control to ensure all eligible facilities are inspected is an unreasonable implementation of the Act's requirement that states exercise "good faith and due diligence" in conducting utilization control inspections. Because the regulation does not contradict the statute's plain language, we uphold the Secretary's interpretation. *See K Mart*, 486 U.S. at 291; *Chevron*, 467 U.S. at 844.

CDSS advances two arguments to demonstrate the regulation is contrary to the express purposes and plain language of the Act. We find neither argument convincing. First, CDSS contends the fact there is an exception for attempted inspections indicates Congress did not intend to require a state to do everything within its control in reviewing each case. On the contrary, to permit a state to avoid the statutory penalty merely because it made a subjective good faith effort to conduct the required inspections would vitiate clearly expressed congressional intent that the care received by each Medicaid recipient be reviewed annually.

Second, CDSS asserts that allowing the Secretary to grant an exception only when a state's failure to inspect is the result of circumstances beyond its control effectively eliminates the exception. The regulation merely limits the availability of the exception to situations where the state has done everything it can to review each recipient's care. The Secretary has

determined this is the diligence due under the Act. Because the identification of the Medicaid recipients receiving care at a particular facility is undeniably an essential element of an inspection, we find the Secretary's determination reasonable. Moreover, under the "technical failings" element of the exception, failures due to circumstances within the state's control can justify an exemption from the penalty. *See* 42 C.F.R.§456.653(b). We are not convinced the regulation is unduly restrictive.

IV. Assessment of the Penalty in this Case

We find the penalty proper in this case. The pertinent facts found by the DAB are either undisputed or supported by substantial evidence in the record. *See Minnesota ex rel. Noot v. Heckler*, 718 F.2d 852, 860 (8th Cir. 1983), *aff'd sub nom. Connecticut Dep't of Income Maintenance v. Heckler*, 471 U.S. 524 (1985). CDSS attempted to inspect the Center by reviewing those patients the Center identified as Medicaid recipients. The Center failed to identify three recipients, and CDSS consequently failed to review the care received by these individuals. CDSS admits these facts and we already have held as a matter of law that failure to review even a single patient constitutes a failure to inspect that facility. Because a failure to inspect indisputably supports the imposition of the statutory penalty, 42 U.S.C.§1396b(g)(5), the DAB's finding of a prima facie case for imposition of the penalty was correct.

The DAB properly concluded that because CDSS's reliance on the facility's census of Medicaid patients was within CDSS's control and did not qualify as a technical failing, the Secretary was permitted to assess the statutory penalty. *See* 42 C.F.R. §456 .653. Further, CDSS does not contest the DAB's finding

that this reliance was a matter within CDSS's control.[5] Rather, CDSS contends Congress intended to allow a state to rely on a facility's census of its Medicaid to determine which patients must be reviewed during an inspection of that facility. Yet the entire purpose of utilization control inspections is to ensure facilities do not provide -- and charge the federal government for -- inappropriate medical care. *See generally* H.R. Rep. No. 231, 92d Cong., 2d. Sess. (1972), *reprinted in* 1972 U.S. Code Cong. & Admin. News 4989, 5092. If states are permitted to rely on a facility's census, a facility providing inappropriate care will be encouraged simply not to list those patients. Thus, the recipients most in need of review would go unreviewed. This is clearly contrary to the underlying purposes of the Act.

We REVERSE the district court's award of summary judgment in favor of CDSS and its refusal to enter judgement in favor of the Secretary. We REMAND for further proceedings consistent with this opinion.

---

[5]CDSS makes a "slippery slope" argument in an attempt to discredit the DAB finding that because CDSS relied on the Center's census of Medicaid patients, CDSS's failure to review each recipient was a circumstance within CDSS's control. CDSS asserts we should disregard the DAB's finding that reliance on the Center's patient list was within CDSS's control. This finding, CDSS claims, is "too rigid" because it implies that a failure to identify can never qualify for the "good faith and due diligence" exception. We fail to see the logic in this argument, and dismiss it summarily.

APPENDIX B

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO

Civil Action No. 89-Z-694

COLORADO DEPARTMENT OF SOCIAL SERVICES,

Plaintiff,

v.

LOUIS W. SULLIVAN, M.D., Secretary of the Department of Health and Human Services, and NORVAL D. SETTLE, ALEXANDER G. TEITZ and JUDITH A. BALLARD, Members of the Departmental Appeals Board, Department of Health and Human Services,

Defendants.

ORDER

This matter was before the Court on September 15, 1989, for oral argument on the Social Security Appeal. The Court heard the arguments and statements of counsel and made oral findings of fact and conclusions of law which are incorporated herein by reference as if fully set forth. Accordingly, it is

ORDERED that Defendants' Motion For Summary Judgment is denied. It is

FURTHER ORDERED that plaintiff's Motion for Summary Judgment is granted. It is

FURTHER ORDERED that the case is remanded to the Secretary for the Secretary to return the $89,428.95 disallowance to plaintiff. It is

FURTHER ORDERED that defendants have sixty (60) days to appeal, and there will be a stay of execution during that period.

DATED at Denver, Colorado, this 21st day of September, 1989.

BY THE COURT:

_____

ZITA L. WEINSHIENK, Judge
United States District Court

September 21, 1989

Civil Action No. 89-Z-694

CERTIFICATE OF MAILING

The undersigned hereby certifies that on the above date copies of ORDER entered by Judge Zita L. Weinshienk and filed on September 21, 1989, were mailed to the following:

Joyce K. Herr
Assistant Attorney General
Human Resources Section
1525 Sherman St., 3d Floor
Denver, CO 80203

James W. Winchester
Assistant U.S. Attorney

JAMES R. MANSPEAKER, Clerk

By Charlotte Hoard
Deputy Clerk

APPENDIX C

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO

Civil Action No. 89-Z-694

COLORADO DEPARTMENT OF SOCIAL SERVICES,

Plaintiff,

vs.

LOUIS W. SULLIVAN, M.D., et al.,

Defendants.

REPORTER'S TRANSCRIPT
(Hearing on Cross-Motions for Summary
Judgment: Bench Ruling)

Proceedings before the HONORABLE ZITA L. WEINSHIENK, Judge, United States District Court for the District of Colorado, commencing at 8:40 a.m., on the 15th day of September, 1989, in Courtroom C-502, United States Courthouse, Denver, Colorado.

APPEARANCES

JOYCE K. HERR, Assistant Colorado Attorney General, 1525 Sherman Street, 3d Floor, Denver, Colorado, 80203, appearing for the plaintiff.

MICHAEL J. NORTON, Acting United States Attorney, by JAMES WINCHESTER, Assistant U.S. Attorney, 1961 Stout Street, 12th Floor, Denver, Colorado, 80294, and PATRICIA L. BOSSERT, Assistant Regional Counsel, Department of Health and Human Proceedings Recorded by Mechanical Stenography, Transcription Produced via Computer by Paul Zuckerman, 1929 Stout Street, P.O. Box 3563, Denver, Colorado 80294, (303) 629-9285, Services, Denver, Colorado, 80294, appearing for the defendants.

* * * * * *

(The following proceedings were had and entered of record after the Court heard arguments of Counsel:)

RULING

THE COURT: It's been suggested to the Court that the *Delaware* case--let me put the cite on the record: 665 F. Supp. 1104, a 1987 case--is not good law; it's a long, involved decision which should not be looked to for its reasoning and analysis.

I would simply indicate that apparently the U.S. did not think that there was a sufficient problem that they properly pursued on appeal, because if, indeed, their appeal was timely

filed and dismissed on that ground, then the case stands as unappealed.

I would also note that the case has been cited in other contexts by the Supreme Court of the United States. One case was *Bowen v. Massachusetts*, 101 L. Ed. 2d 749, which is a fairly recent Supreme Court decision and which cites this case with approval. This is a 1988--June of '88 decision of the Supreme Court; and on page 773 of the L.Ed. text, Footnote 46, the *Delaware* case is cited, not on this very point.

We have a situation where we have statutes which spell out very, very strict standards and also spell out an exception. The statute that we're talking about indicates an exception to the 100 percent reporting requirement as follows:

"The Secretary shall find a showing of a state to be satisfactory if the showing demonstrates that the state has conducted such an on-site inspection during the 12-month period ending on the last date of the calendar quarter

"(i) in each of not less than 98 percent of the number of such hospitals and facilities requiring such inspection and

"(ii) in every hospital or facility which has 200 or more beds."

Let me just say, interrupting the quote, that apparently there is no question that the state did meet the 98 percent figure; and it appears that the facility in question here does have less than 200 beds.

The statute goes on to say "and that with respect to such hospitals and facilities not inspected within such period, the state has exercised good faith and due diligence in attempting to

conduct such inspection, or if the state demonstrates to the satisfaction of the Secretary that it would have made such a showing but for failings of a technical nature only."

And again, in this case, I think we have no question concerning bad faith. It's agreed that there is good faith; so we are, as pointed out by Mr. Winchester, really talking about due diligence.

Now, the Secretary in this case is asking the Court, contrary to this decision of the judge in the *Delaware* case, to impose a very strict objective standard. And the question is whether that is mandated or required, or the intent of the statute in question, or whether that as argued by the judge in the *Delaware* case, the standard is a subjective standard. On page 1124 of the decision in the *Delaware* case, the judge says the following:

"The state also argues that the regulations are invalid because the Secretary's interpretation of the good faith and due diligence and of the technical failings exceptions are impermissibly more restrictive than those provided in the Social Security Act. The regulations interpreted good faith and due diligence to mean, 'circumstances beyond the agency's control,'" citing the regulations. "This is an objective standard requiring the state to prove objectively that because of some factor beyond its control, the state cannot review the facility; but the legislative history implicitly requires a subjective standard. The conferees' agreement on the 1977 Social Security Act amendments provides that, 'If a facility is not reviewed, there will be a reduction in matching unless the Secretary finds there was a good faith attempt to review the institution and there is no evidence that any institution or any kind of institution is deliberately not reviewed.'" There is citations which I'll omit.

And then the decision goes on to say, "By using the

term 'attempt' and by mandating that facilities are not deliberately unreviewed, the legislature plainly directed the Secretary to employ a subjective standard that focuses on the state's good faith. This interpretation comports with the statutory language that requires a showing that the state 'has exercised good faith.'"

It goes on, but that's the holding concerning whether good faith and due diligence should be interpreted with a very strict objective standard or a subjective standard.

In my considered opinion, if this court were to interpret the section, the exception to the statute as the defendants are arguing it, it would for all intents and purposes eliminate the exception. In my considered opinion, that part of the case, at least-- the *Delaware* case-- I'm not going to go into all of it, but that part which deals with this subject and the interpretation and legislative history does comport with the law; and the legislative history does support the fact that Congress intended not the extremely strict interpretation that would eliminate the exception that is being argued by Defendants but rather it is the more subjective, good faith/due diligence consideration that admittedly applies in this case.

We are talking about missing three recipients out of thousands of recipients. We are talking about not anything deliberately done, but we are talking about a rather technical mistake, an inadvertent mistake in a facility of less than 200 beds. We are talking about reliance ont he facility's figures, which seems very reasonable; and I'm sure the state is not going to rely on these anymore, because there was this guideline. But the guideline was January, '88, effective February, '88, applying to the survey and the statistics for the spring, March, April of '88. So it's understandable if it was not immediately put into their system and put into full effect when it just came out.

After consideration, the Court finds that the reasoning of this case was not appealed for whatever reason, the *Delaware* case, is well reasoned. I agree with their holding and with their analysis, with the analysis of that case; and accordingly, for the reasons that I have stated and that are stated in the case of *Delaware Division of Health and Social Services v. U.S. Department of Health and Human Services*-- the cite has been put in the record--the Court will order that the--this court has jurisdiction of this matter and that the plaintiff's motion for summary judgment is granted; that the defendant's motion for summary judgment is denied; that the agency order is reversed as contrary to law. And the Court will so find that it is contrary to law; and the Court will at this time enter judgment for Plaintiff and order the Secretary to allow the $89,428.95 to the plaintiff. Costs will be awarded to the plaintiff. Each side, however, should pay their own--its own attorney fees.

And let me ask whether there is any further findings or orders that are necessary in order to bring this to final judgment. And then we leave it up to the defendant whether they want to pursue an appeal of this case.

MS. HERR: I don't believe anything further is necessary.

MR. WINCHESTER: Your Honor, just to make sure I understand, there is some dispute of authority whether under the Administrative Procedure Act the Court could enter what in effect is a money judgment. The way we interpret it is basically the case is being remanded to the Secretary to award the back pay, then.

THE COURT: I think probably you're correct. That's the way it should be stated. Let me just see what the *Delaware* case did.

In the *Delaware* case, the judge said, "HHS is ordered immediately to return any disallowance penalty assessed to Delaware."

The Court will order this case remanded to the Secretary to return the--what is it, 89-plus thousand penalty disallowed.

Let me just indicate, because if this case is going to be appealed, I want to be very clear that this court, rather than repeating some of the details that are in the *Delaware* case, is incorporating by reference the law and the reasoning stated on this legal issue by the *Delaware* case. I see nothing to be gained by reading from more of the case; but that case does go on to discuss when a regulation is promulgated and is more restrictive than the standards by the statute, it's void, citing cases. I am incorporating by reference that reasoning that was in that *Delaware* case.

Any questions? Is there going to be any stay of execution requested, or what is your thought on that?

MR. WINCHESTER: Your Honor, we usually have 60 days to determine whether an appeal would be taken. I would request that execution of the remand be stayed during our time to file notice of appeal.

THE COURT: Any objections?

MS. HERR: No objection.

THE COURT: All right. THe defendant has 60 days to appeal, and there will be a stay of execution during that 60 days. If you decide not to appeal, then you should go ahead and make the arrangements with the state.

Court will be in recess, and we have another case

coming up at 9:30.

(Thereupon, the hearing was concluded and the Court recessed at 9:20 a.m.)

* * * * * *

REPORTER'S CERTIFICATE

I certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled matter.

Dated at Denver, Colorado, this 21st day of September, 1989.

_____

Paul A. Zuckerman

APPENDIX D

DEPARTMENT OF HEALTH & HUMAN SERVICES
Office of the Secretary

Departmental Appeals Board
Room 637D, HHH Building
200 Independence Avenue, SW
Washington, D.C. 20201

RETURN RECEIPT REQUESTED

Patricia L. Bossert
Assistant Regional Counsel
DHHS - Region VIII
Room 1106
19th and Stout Streets
Denver, Colorado 80294

and

Joyce K. Herr
Assistant Attorney General
Human Resources Section
Colorado Department of Social Services
1525 Sherman Street, 3rd Floor
Denver, Colorado 80203

Re: Decision in the Appeal of Colorado Department of Social Services
Docket No. 88-206
Decision No. 1027
Date: March 15, 1989

Counsel:

Enclosed is a copy of the decision of the Departmental Appeals Board in the appeal identified above. The decision constitutes the final administrative action on this matter.

Sincerely yours,

Neil H. Kaufman
Executive Secretary
Departmental Appeals Board

Enclosure

APPENDIX E

DEPARTMENTAL APPEALS BOARD

Department of Health and Human Services

Subject: Colorado Department of Social Services
Docket No. 88-206
Decision No. 1027

Date: March 15, 1989

DECISION

The Colorado Department of Social Services (Colorado/State) appealed a determination by the Health Care Financing Administration (HCFA/Agency) disallowing $89,428.95 in federal funding claimed by the State under the Medicaid program of the Social Security Act (Act) for the quarter ending March 31, 1988. The disallowance was taken pursuant to section 1903(g)(1) of the Act, which provides for the reduction of a state's federal medical assistance percentage of amounts claimed for a calendar quarter for long-stay services where the State fails to show that during the quarter it had "an effective program of medical review of the care of patients . . . whereby the professional management of each case is reviewed and evaluated at least annually by independent professional review teams."

HCFA found that Colorado had failed to conduct a satisfactory on-site inspection of care review at Spring Creek Health Care Center (Spring Creek) because the State review team did not include three Medicaid recipients in its review of that facility. Spring Creek is a dually certified facility providing both skilled nursing facility (SNF) and intermediate care facility (ICF) services. Two of the cited recipients were receiving ICF

services; the other was a SNF patient.[1] Colorado relied on the facility's patient census lists to determine the Medicaid recipients due for review. HCFA asserted that the State system for identifying recipients due for review was faulty and that, consequently, Colorado had not satisfied the Medicaid standard of reviewing each recipient for whom a review was due. The State conceded that the cited recipients should have been reviewed, but offered two defenses to the disallowance. Colorado contended that it had met the annual review requirement even though three recipients were not reviewed, and alleged that HCFA's interpretation of the statutory review requirement set out in the implementing regulations was arbitrary and capricious. Additionally, Colorado asserted that its failure to review these recipients could be excused under the "good faith and due diligence" exception to the annual review requirement.

Based on the following analysis, we reject Colorado's arguments and sustain the disallowance.

What the statute and regulations provide

Section 1903(g)(1) of the Act requires a state to make a quarterly showing that it has an effective program of medical review of the care of Medicaid recipients in ICFs and SNFs pursuant to section 1902(a)(31) of the Act, whereby the professional management of *each* case is reviewed and evaluated at least annually.[2] Section 1902(a)(31)(B) of the Act requires

---

[1]The total disallowance of $89,428.95 included $23,825.95 disallowed for SNF services and $65,603 disallowed for ICF services.

[2]HCFA has implemented this requirement through annual facility reviews so that a state need not track each individual recipient. A state thus meets the annual review requirement by ensuring the review of each reasonably

periodic onsite inspection of the care being provided *each* Medicaid recipient in these facilities. These requirements are implemented by regulations at 42 C.F.R. Part 456, Subpart I and section 456.652. Under these regulations, a review team must personally contact and observe each Medicaid recipient, review that recipient's medical records, and evaluate whether the services provided are adequate and necessary to meet the recipient's needs or whether a less costly care alternative is feasible.

If the Secretary determines that a state's quarterly showing is unsatisfactory or invalid, the state's funding for long-stay services is reduced in accordance with the formula at section 1903(g)(5).

Section 1903(g)(4)(B) sets out circumstances in which the Secretary shall find a state's showing satisfactory, notwithstanding the state's failure to conduct all required reviews. Specifically--

> [t]he Secretary shall find a showing of a State . . . to be satisfactory . . . if the showing demonstrates that the State has conducted such an onsite inspection during the 12-month period ending on the last date of the calendar quarter--
>
> (i) in each of not less than 98 per centum of the number of such hospitals and facilities requiring such inspection, and
>
> (ii) in every such hospital or facility which has

---

identifiable recipient present during the annual review at each facility. *See, e.g., Kansas Dept. of Social and Rehabilitation Services*, DAB No. 993 (1988); *Washington State Dept. of Social and Health Services*, DAB No. 940 (1988).

200 or more beds,[3]and that, with respect to such hospitals and facilities not inspected within such period, the State has exercised good faith and due diligence in attempting to conduct such inspection, or if the State demonstrates to the satisfaction of the Secretary that it would have made such a showing but for failings of a technical nature only.

This section of the Act is implemented by the regulations at 42 C.F.R. 456.653, which provide in pertinent part--

> The Administrator [of HCFA] will find an agency's showing satisfactory, even if it failed to meet the annual review requirements of section 456.652(a)(4), if--
>
> (a) The agency demonstrates that--
>
> (l) It completed reviews by the end of the quarter or at least 98 percent of all facilities requiring review by the end of the quarter;
>
> (2) It completed reviews by the end of the

---

[3]The 98% requirement pertains not to the number of facilities in a particular level of care under review during a quarter, but to the completion of reviews in 98% of the combined total of *all* facilities where such a review was required by 1903(g)(1) during the 12-month period ending with the close of the quarter in question. *See* HCFA Action Transmittal-77-106, November 11, 1977, p. S; 43 Fed. Reg. 50925 (November 1, 1978); 44 Fed. Reg. 56336-56337 (October 1, 1979). For example, assuming a state had a total of 100 intermediate care facilities, skilled nursing facilities, and mental hospitals due for review during the annual period from April 1, 1987 through March 31, 1988, the state would meet the 98%/200 bed standard for its showing submitted for the quarter ending March 31, 1988 if it completed reviews during the annual period in 98 facilities including all those with 200 or more certified Medicaid beds.

quarter in all facilities with 200 or more certified Medicaid beds requiring review by the end of the quarter; and

(3) With respect to all unreviewed facilities, the agency exercised good faith and due diligence by attempting to review those facilities and would have succeeded but for events beyond its control which it could not have reasonably anticipated; or

(b) The agency demonstrates that it failed to meet the standard in paragraph (a)(l) and (2) of this section by the close of the quarter for technical reasons, but met the standard within 30 days after the close of the quarter. Technical reasons are circumstances within the agency's control.

Background

Colorado inspection teams charged with performing annual reviews at long-term care facilities rely solely on the particular facility's census of Medicaid patients to identify recipients due for review. This procedure resulted in three recipients being omitted from the March 1988 Spring Creek review. Colorado conceded that these recipients should have been included in the Spring Creek review. The recipients were eventually reviewed in June 1988 after HCFA notified Colorado that they were omitted from the original review. Colorado Brief (Br.), p. 2; HCFA Br., p. 8.

Colorado conceded that it was clearly the intent of Congress that each Medicaid patient in each facility receive an annual review. Colorado argued that it had satisfied the annual review requirement in that each of the cited recipients had been

reviewed within six months of their eligibility, and would be reviewed again within the one year period ending in March 1989. Colorado Br., p. 3. Alternatively, Colorado contended that its failure to include these three recipients in the March annual review could be excused under the "good faith and due diligence" exception to the annual review requirement. Colorado argued that HCFA's regulatory interpretation of this exception was unreasonably restrictive in that the Agency held states to an objective standard rather than to the subjective standard intended by Congress, citing *Delaware Div. of Health and Social Services v. U. S. Dept. of Health and Human Services*, 665 F. Supp. 1104 (D. Del. 1987), *appeal dismissed* (as untimely filed), C.A. No. 87-3602 (3rd Cir., October 6, 1987). Essentially, Colorado asserted that HCFA has impermissibly restricted the plain meaning of the phrase "good faith and due diligence" by tying the exception to events which are "beyond the control" of the party. Rather than applying an absolute standard, Colorado insisted that its actions should be measured by a standard which anticipates that a state would "operate its inspection function in a reasonable and prudent manner . . . [and assumes] that the results will not achieve perfection. " Colorado Br., pp. 5-6.

Under its interpretation of the regulation, Colorado claimed that it could reasonably rely on a facility's census to identify Medicaid recipients due for review. Colorado asserted that this was the method used by most states to identify recipients. Colorado conceded that where a state had information with which it could verify the accuracy of a census it would be reasonable to expect the state to do so . However, Colorado contended that absent such information "'due diligence' does not require a higher standard of extraordinary care." *Id.* at 7 . Responding to HCFA'S allegation that the State had provided information to HCFA which could have been used to identify recipients, Colorado admitted that its Professional Review Organization (PRO) entered eligibility

information into its computers on a daily basis . However, Colorado said the PRO generated only monthly reports. Consequently, the State concluded, the "PRO reports would be of minimal assistance at the time of the inspection. " *See* Colorado Reply Br., p. 2; *see also* HCFA Br., pp. 7-8.

Analysis

Below, we first discuss the history of the "good faith and due diligence" exception and why we think that HCFA's interpretation of that exception is reasonable. We then discuss why the exception does not apply to the circumstances of this case, and why we reject the State ' s contention that it met the annual review requirement.

The "good faith and due diligence" exception

Section 1903(g)(4)(B) was added to the Act by Public Law 95-142, enacted October 25, 1977. On November 11, 1977, HCFA issued Action Transmittal HCFA-AT-77-106 (AT-77-106) to state agencies administering the Medicaid program. AT-77-106 discussed the legislative history and effect of section 1904(g)(4)(B).[4] Regarding the "good faith and due diligence" standard, the Action Transmittal noted that House committee reports clearly indicated that Congress did not intend to permit states to aim for less than 100% performance of the review requirement; rather, the "good faith and due diligence" exception was "intended to permit an exception to the 100% requirement in situations clearly beyond the State's control." In reaching this conclusion, HCFA relied on its view that the exception was intended to formalize existing HCFA practice.

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[4]The legislative history of section 1903(g)(4)(B) was thoroughly discussed and considered by this Board as early as 1979 in *Ohio Dept. of Public Welfare*, DAB No. 66 (1979).

HCFA provided examples of circumstances beyond a state's control and specifically noted that the exception would not excuse disorderly record keeping. AT-77-106, pp. 6-7.

Approximately one year after publishing AT-77-106, HCFA issued a Notice of Proposed Rulemaking (NPRM) setting out for comment a draft of the regulations implementing Public Law 95-142. HCFA provided the following guidance regarding "good faith and due diligence"--

> We propose to excuse under the good faith and due diligence exception only those failures to perform reviews which are due to situations clearly beyond the State agency's control. Under this exception, failures to perform reviews due to recurring or predictable weather conditions would not be excused. Furthermore, if a State employee strike or severe blizzard or other situation beyond a State's control resulted in less than 98 percent performance, a State would be subject to a reduction for all missed reviews.

43 Fed. Reg. 50925 (November 1, 1978).

In the preamble to the final rule, HCFA indicated that the "good faith and due diligence" exception would apply--

> . . . if the 98 percent and 200 bed adherence level was achieved by the close of the showing quarter, and the failure to achieve 100 percent compliance was clearly beyond the agency's control and could not have been reasonably anticipated.

44 Fed. Reg. 56335 (October 1, 1979).

After some discussion of the comments, and the genesis of the exception, HCFA noted that it would retain the "good faith and due diligence" exception "as published in the NPRM." *Id.* at 56335-56336.

Why HCFA's interpretation is reasonable

We first note that HCFA's interpretation is a longstanding one, adopted nearly ten years ago almost immediately after enactment of the provision. As we noted earlier, HCFA viewed the good faith and due diligence exception as formalizing its prior practice of not finding a state's showing unsatisfactory where reasons entirely beyond a state's control made it impossible for the state to meet review requirements. HCFA's view was consistent with language in the Senate bill, which would have authorized waiver of a section 1903(g) disallowance "in any case in which the Secretary determines that the unsatisfactory or invalid showing made by the State is of a technical nature only, or is due to circumstances beyond the control of the State." In explaining this provision, the Senate Finance Committee report stated that the bill would waive a disallowance--

> if the State's noncompliance is technical or due to circumstances beyond its control. The committee intends, however, that this waiver authority is to be invoked only when reasonably appropriate and not as a generalized routine exception. Circumstances considered outside of a State's control are those which could not reasonably be anticipated and provided for in advance.

S. REP. No. 453, 95th Cong., 1st Sess. 40 (1977).

HCFA examined the legislative history of section 1903(g)(4)(B) in the preambles to its proposed and final regulations and concluded that the "good faith and due diligence" language combined the Senate and the House versions of this exception. HCFA's regulations, adopted in light of this conclusion, provide that this exception applies where there are "circumstances beyond [a state's] control which it could not have reasonably anticipated." 42 C.F.R. 456.653.

One court which has examined this exception concluded that it was a "subjective" standard, calling for an evaluation of a state's intent rather than consideration of objective factors. *Delaware, supra*, at 1128. In our view this is incorrect.[5] While the conference report states that there must be no evidence that a state deliberately did not review a facility, we think that the legislative history as a whole shows that mere subjective intent to review all facilities is not sufficient to qualify for the exception.[6] Moreover, the *Delaware* court focused on the concept of "good faith," without considering the concept of "due diligence." In our view, HCFA's regulatory standard embodies its programmatic judgment that a state exercising the diligence which a state should exercise in medical reviews would be able to meet the annual review requirements unless prevented from doing so due to circumstances beyond the state's control which the state could not reasonably anticipate. While HCFA's

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[5]For a thorough discussion of the court's decision in *Delaware*, see *Nebraska Dept. of Social Services*, DAB No. 972 (1988), where we stated why we were not bound by *Delaware*.

[6]AT-77-106, issued shortly after enactment of the section, gave examples of circumstances which would fall within the exception, such as where a facility is quarantined at the time of its scheduled review or where the facility would not permit the team on-site without a court order. While the examples given might be regarded as somewhat extreme, they clearly indicate that HCFA considered the exception as applying to objective circumstances, not merely subjective intent.

regulation sets a high standard, in our view this reflects the importance of the annual review requirements in ensuring quality care for each Medicaid recipient in a long-term care facility and in reducing costly expenditures for such care if it is not needed.

In sum, HCFA's regulation is a reasonable implementation of the statutory provision. It contains a longstanding interpretation, consistent with the statutory language and history and with the purposes of the annual review requirement.

The good faith and due diligence" exception is inapplicable

Having determined that HCFA'S interpretation of the "good faith and due diligence" exception as presented in the implementing regulations is not arbitrary and capricious, we next address why the exception does not apply to the facts of this case.[7]

A key element to the application of the exception is that a state be unable to review each recipient in every facility due to circumstances "beyond its control which it could not have reasonably anticipated . . . . " 42 C.F.R. 456.653(a)(3). Colorado was not prevented from reviewing each recipient at Spring Creek due to circumstances beyond its control. These patients were unreviewed due to the State's absolute reliance upon the facility's census to identify recipients due for review.

---

[7]Spring Creek's skilled and intermediate facilities each contain less than 200 Medicaid beds. Colorado Br., p. 2. Further, HCFA had not alleged that Colorado failed to review 98% of facilities requiring inspection by March 31, 1988. Thus, the State has met the threshold standard for application of the statutory exceptions.

Identification of recipients due for review is clearly a circumstance within a state's control.[8]

As HCFA noted, we have found that the state bears the ultimate responsibility for conducting satisfactory annual reviews. *See North Carolina Dept. of Human Resources*, DAB No. 728 (1986). Colorado did no more than assert that it was justified in relying upon the facility's census to identify the recipients. Instead, Colorado merely offered the unsupported assertion that most states rely on facility census information to identify Medicaid recipients due for review. Numerous Board cases have addressed states' systems for identifying Medicaid recipients in a facility due for review; some states use computer-generated lists while others have found other ways of double-checking information provided by facilities. *See generally Utah Dept. of Health*, DAB No. 843 (1987) (review team conducted room-by-room review as a back-up for accuracy of recipient list); and *Oregon Dept. of Human Resources*, DAB No. 895 (1987) ("pending" Medicaid recipients reviewed).

Colorado asserted that while its PRO entered eligibility

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[8]Given that identification of recipients is a circumstance within a state's control, a question of the possible application of the technical failings exception arises. The technical failings exception applies to circumstances within a state's control. *See* 42 C.F.R. 456.653. This Board has found that the technical failings exception may apply to excuse a singular occurrence, in an otherwise satisfactory system, but may not apply to excuse a systemic problem which evidences poor administration, such as here. *See, e.q., Illinois Dept. of Public Aid*, DAB No. 930 (1987); *Arkansas Dept. of Human Services*, DAB No. 923 (1987); *New Hampshire Dept. of Health and Human Services*, DAB No. 841 (1987). The State did not assert that this exception should apply to excuse the untimely review at Spring Creek. Additionally, as our analysis shows, neither the facts of this case nor the State's reasons for failing to review all the Spring Creek review all the Spring Creek recipients convince us that the technical failings exception could apply.

information into its computer system on a daily basis, the State could not be expected to rely upon that information to identify recipients since the PRO reports were generated only on a monthly basis. Colorado characterized HCFA's suggestion that it rely on this information as "a senseless act . . . unreasonable, arbitrary and capricious." Colorado Reply Br., p. 7. Yet, the facts as presented by Colorado indicate that use of the PRO information would have enabled the State to identify as Medicaid eligible at least two of these omitted recipients. The review at Spring Creek was conducted on March 17, 1988. HCFA Exhibit (Ex.) 1. Recipient H.E.[9] was approved for Medicaid at the ICF level on March 1, 1988, effective February 17, 1988. Recipient J.W. was approved for Medicaid at the SNF level on January 6, 1988, effective November 1, 1987. The case of recipient M.S. (an ICF patient) was characterized by the State as "unusual as she had not been listed by the facility for more than 1 year." Colorado Br., p. 3. Even if the State had used a one month old PRO report to identify recipients, it would have been able to identify at least one recipient at each level of care (J.W. and M.S.), thereby eliminating the SNF disallowance.[10] If the report was generated after the first of March, use of the report would have also prevented the failure to review recipient H.E. Thus, contrary to

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[9]Patients are identified by their initials to protect their privacy.

[10]Carrying this hypothetical one-step further, we note that the Board has recognized that when states rely on computer generated lists to identify recipients due for review, there may be some lag time between when a recipient's status is determined and when that status appears on a computer printout and is reasonably available to a review team. Thus, a state could possibly conduct a review before such a list is updated and miss recipients otherwise due for review. In certain cases, we have found that states may reasonably rely on such lists to identify Medicaid recipients. *See, e.a., Texas Dept. of Human Resources*, DAB No. 830 (1987); *Idaho Dept. of Health and Welfare*, DAB No. 747 (1986).

Colorado's assertion, reliance on a Pro report would not be a senseless act, but could have served as a reliable back-up to assist the State in accurately identifying all recipients for whom a review was due.

Also, Colorado could have used other information to verify the recipients' status; HCFA noted that, for purposes of the Agency's validation survey, the State had provided certain recipient billing information which could have been used to verify the facility's census. HCFA Br., pp. 7-8; *see also* HCFA Exs. 4 and 5. Colorado provided no adequate explanation of why it could not have used this information or, alternatively, have developed a more accurate system, as other states have, to ensure including all recipients in a facility review. Nor did the State explain why it would be reasonable to rely on information provided by the facilities. Indeed, the State did not even explain why the facility's census here was not accurate.

The State correctly asserted that the statutory standard of review "anticipates" that a state's review process will not achieve perfection; but Congress clearly expected states to exercise due diligence in reviewing the quality of, and need for, each recipient's long-term care. As the Agency recognized in its NPRM--

> The committee reports accompanying Pub. L. 95-142 make clear that this amendment was not intended to permit agencies to aim for less than 100 percent performance of the review requirement. Rather, it was intended to permit a limited exception to the 100 percent requirement in specified situations. (See 95th Cong., 1st session, House Conference Rept. 95673, p. 48.)

43 Fed. Reg. 50925 (November 1, 1978).

Regarding Colorado's contention that it had met the annual review requirement since these recipients were reviewed within six months of their eligibility, we note that while Congress did intend that each recipient in every facility be reviewed at least annually HCFA implemented this review requirement by means of a system of facility reviews. *See* note 1. Thus, the State was required to review all recipients in Spring Creek during the March 1988 annual review, regardless of the length of time those patients had been Medicaid recipients. Additionally, we question Colorado's assertion that each recipient was reviewed within six months of their eligibility determination, in light of Colorado's admission that recipient M.S. had been "unlisted" for more than one year. Here, the fact that these recipients were ultimately reviewed in June 1988 was not attributable to any aspect of the State's system, such as reviews which were conducted every six months. *See Maine Dept. of Human Services*, DAB No. 857 (1987) (state system of semi-annual reviews found to satisfy the annual review requirement). Rather, these reviews occurred only due to the fact that HCFA's validation survey brought the missed reviews to the State's attention.

We must also reject Colorado's contention that the "good faith and due diligence" exception applies to excuse the missed reviews since it did not subjectively intend to miss these recipients. Colorado Br., p. 6. As we have discussed above, the "good faith and due diligence" exception is not based on the absence of an intent not to review. If the focus were on intent, any state could avoid a disallowance merely by asserting a lack of intent to not review. Consequently, anything shy of deliberate maladministration would be forgiven. Under such a broad interpretation, the purpose of the statutory reduction of federal funding for an unsatisfactory showing would be negated. *See Pennsylvania Dept. of Public Welfare*, DAB No. 1014 (1989), pp. 12-13.

Here, Colorado's absolute reliance on the facility's census is insufficient to support a finding that the State exercised good faith and due diligence in conducting the annual review and was prevented from reviewing all the recipients due to circumstances beyond its control. In spite of the fact that the State is charged with the responsibility of reviewing all recipients in each facility, the State did no more than send its review teams to the facility with the hope that the facility would accurately identify all the recipients. The identification of Medicaid recipients due for review is certainly a circumstance within a state's control. However, Colorado employed no back-up system to double check the accuracy of the facility's census, even though information was readily available. These facts support a finding that Colorado did not act with the diligence due to ensure that the statutory requirement of an annual review of each recipient in each facility was met.

Conclusion

Based on the preceding analysis, we sustain the disallowance of $89,429.

Norval D. (John) Settle

Alexander G. Teitz

Judith A. Ballard
Presiding Board Member

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No. 90-1964

In the Supreme Court of the United States

OCTOBER TERM, 1991

THE COLORADO DEPARTMENT OF SOCIAL SERVICES, PETITIONER

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE TENTH CIRCUIT

BRIEF FOR THE RESPONDENTS IN OPPOSITION

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QUESTION PRESENTED

The Medicaid statute requires a State to show, under penalty of a partial loss of funding, that it has inspected each of a certain class of medical facilities in the State by conducting an annual review of the medical care provided each Medicaid recipient in those facilities. The statute also provides a safe harbor with respect to facilities not inspected if the State can show, *inter alia*, that it exercised "good faith and due diligence in attempting to conduct" the required inspections. 42 U.S.C. 1396b(g)(4)(B). The question presented is whether the Secretary of Health and Human Services reasonably interpreted this "good faith" and "due diligence" statutory safe harbor as requiring a State to show that it "would have succeeded [in conducting a 100% review] but for events beyond its control which it could not have reasonably anticipated." 42 C.F.R. 456.653(a)(3) (1990).

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ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE TENTH CIRCUIT

BRIEF FOR THE RESPONDENTS IN OPPOSITION

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 13-23) is reported at 928 F.2d 961. The oral opinion and order of the district court (Pet. App. 25-36) and the decision of the Departmental Appeals Board (Pet. App. 39-54) are both unreported.

JURISDICTION

The judgment of the court of appeals was entered on March 22, 1991. The petition for a writ of certiorari was filed on June 20, 1991. This Court's jurisdiction is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. Under the Medicaid program established by Title XIX of the Social Security Act, 42 U.S.C. 1396 *et seq.*, the federal government provides financial assistance to participating States to reimburse facilities for health care provided to qualified Medicaid recipients. To receive federal Medicaid funds, each participating State must make a "showing satisfactory to the Secretary" that it has "an effective program of medical review of the care of patients" in certain facilities in the State "whereby the professional management of each case is reviewed and evaluated at least annually by independent professional review teams." 42 U.S.C. 1396b(g)(1). See also 42 U.S.C. 1396a(a)(26) and (31). The reviews are referred to as "utilization control inspections." A State failing to inspect all eligible facilities within its borders is subject to a reduction in federal payments (generally one-third of the Medicaid funds that were supplied to the State for care in the uninspected facility for the quarter in which the failure to inspect occurred). See 42 U.S.C. 1396b(g)(5).

The statute provides a safe harbor for States that fail to complete all required inspections:

> The Secretary shall find a showing * * * to be satisfactory, * * * if the showing demonstrates that the State has conducted such an onsite inspection during the 12-month period ending on the last date of the calendar quarter—
>
> > (i) in each of not less than 98 per centum of the number of such hospitals and facilities requiring such inspection, and
> >
> > (ii) in every such hospital or facility which has 200 or more beds,

> and that, with respect to such hospitals and facilities not inspected within such period, the State has exercised good faith and due diligence in attempting to conduct such inspection, or if the State demonstrates to the satisfaction of the Secretary that it would have made such a showing but for failings of a technical nature only.

42 U.S.C. 1396(g)(4)(B). The Secretary has promulgated regulations implementing these requirements. See 44 Fed. Reg. 56,333, 56,335-53,336, 56,339 (1979), promulgating 42 C.F.R. 456.653 *et seq.* The regulations define "good faith and due diligence" as full statutory compliance "but for events beyond [the State's] control which it could not have reasonably anticipated." The regulations also define "failings of a technical nature" to include all "circumstances within the [State's] control" but permit correction of such failings only "within 30 days after the close of the [calendar] quarter" at issue. 44 Fed. Reg. 56,335-56,336 (1979).

2. In the Spring of 1988, when the events at issue in this case took place, the above inspection, penalty, and safe harbor provisions applied to persons receiving "skilled nursing facility care or * * * care in a mental hospital" (42 U.S.C. 1396a(a)(26) (1982))[1] and persons receiving care in an "intermediate care facility" (42 U.S.C. 1396a(a)(31) (1982)).[2] The

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[1] "Skilled nursing facility services" were defined as "services which are or were required to be given an individual who needs or needed on a daily basis skilled nursing care (provided directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitation services which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis." 42 U.S.C. 1396d(f) (1982).

[2] An "intermediate care facility" was generally defined as "an institution * * * licensed under State law to provide, on a

1987 Omnibus Budget Reconciliation Act (OBRA) eliminated skilled nursing facilities and most intermediate care facilities from the scope of the inspection, penalty, and safe harbor provisions with respect to services furnished after October 1, 1990. After that date, the inspection, penalty, and safe harbor provisions apply only to a subclass of intermediate care facilities—"intermediate care facilities for the mentally retarded"—and mental hospitals.[3] See Pub. L. No. 100-203, Tit. IV, §§ 4212(d)(1), 4214(a) and (c), 101 Stat. 1330-212, 1330-219. Skilled nursing facilities and intermediate care facilities that were removed from the coverage of the inspection, penalty, and safe harbor provisions are now subject to a different assessment and state certification process. See generally 42 U.S.C. 1396r(b)(3), 1396r(g).

3. The Secretary periodically conducts surveys in a sample of covered facilities to ensure that States are properly performing utilization control inspections. 42 U.S.C. 1396b(g)(2). In May 1988, a federal survey of a sampling of covered facilities in Colorado revealed that petitioner had failed to review

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regular basis, health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities." 42 U.S.C. 1396d(c) (1982). Intermediate care facilities include institutions for the mentally retarded if they meet certain other conditions. 42 U.S.C. 1396d(d) (1982 & Supp. IV 1986).

[3] Intermediate care facilities for the mentally retarded were formerly included among intermediate care facilities generally. Compare 42 U.S.C. 1396d(d) (1988) with 42 U.S.C. 1396d(d) (1982 & Supp. IV 1986).

the care provided three Medicaid recipients at the Spring Creek Health Care Center in Fort Collins, Colorado. Pet. App. 39-40.[4] Petitioner's "inspection teams charged with performing annual reviews * * * [had] rel[ied] solely on the particular facility's census of Medicaid patients to identify the recipients due for review" and had done nothing further to verify that the facility-provided patient list was accurate. *Id.* at 43. After notification of the error on June 8, 1988, petitioner finally reviewed the patients on June 10, 1988. *Ibid.* On September 19, 1988, the Secretary assessed a penalty against petitioner of $89,428.95 for its failure to perform a satisfactory utilization control inspection for the Spring Creek facility for the quarter ending March 31, 1988. *Id.* at 39.

Petitioner appealed the penalty to the Secretary's Departmental Appeals Board (DAB). Pet. App. 39-54. Petitioner argued that its reliance on the facility's patient census met the statutory "good faith" and "due diligence" safe harbor and that the Secretary "impermissibly restricted the plain meaning of th[at] phrase * * * by tying the exception to events which are 'beyond the control' of the party." *Id.* at 43-44. The DAB rejected petitioner's argument, reasoning that the Secretary's interpretation was reasonable and that petitioner had available other information that it could have used to verify the Spring Creek patient list.[5] *Id.* at 45-54.

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[4] Spring Creek is dually certified as both a skilled nursing facility and an intermediate care facility. Two of the cited recipients were receiving intermediate care facility services and the third was a skilled nursing facility patient. Pet. App. 39-40.

[5] The DAB found that use of Peer Review Organization (PRO) eligibility information "would have enabled [peti-

4. Petitioner filed the instant suit challenging the DAB's decision. On cross-motions for summary judgment, the district court ruled in favor of petitioner. Pet. App. 29-36. Expressly adopting the holding and reasoning of the district court in *Delaware Division of Health & Social Services* v. *HHS*, 665 F. Supp. 1104 (D. Del. 1987), the district court held that Congress intended to adopt a subjective standard for the statutory "good faith"/"due diligence" safe harbor and that petitioner's "inadvertent mistake" met that standard. Pet. App. 33-35.

The court of appeals reversed. Pet. App. 13-23. The court first concluded that the Medicaid statute made clear that "a failure to review a single recipient constitutes a failure to inspect a facility for purposes of the penalty provision." *Id.* at 18-19. Thus, petitioner's "admitted failure to review three recipients at the [Spring Creek] Center * * * represents a failure to inspect that facility" for purposes of the statute. *Ibid.* Turning to an analysis of the safe harbor provision, the court applied the approach outlined in *Chevron U.S.A. Inc.* v. *NRDC, Inc.*, 467 U.S. 837 (1984), and concluded that "Congress did not [directly] address" the meaning of "good faith" and "due diligence" in the statute but rather "implicitly delegated to the Secretary the determination of how 'good faith and due diligence' should be measured." Pet. App. 19-20. The court also concluded that the Secretary's interpretation of that provision was reasonable:

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tioner] to identify as Medicaid eligible at least two of these omitted recipients." Pet. App. 51. The DAB also found that "for purposes of [the Secretary's] validation survey, the State had provided certain recipient billing information which [also] could have been used to verify the facility's census." *Id.* at 52.

> The Act repeatedly expresses the goal that states annually review the care received by *each* Medicaid recipient. We cannot say the regulation's requirement that a state do everything within its control to ensure all eligible facilities are inspected is an unreasonable implementation of the Act's requirement that states exercise "good faith and due diligence" in conducting utilization control inspections. Because the regulation does not contradict the statute's plain language, we uphold the Secretary's interpretation.

Id. at 21.

The court rejected petitioner's argument that a state should be able to avoid the statutory penalty merely by making a subjective good faith effort to conduct the required inspections, concluding that such an approach "would vitiate clearly expressed congressional intent that the care received by each Medicaid recipient be reviewed annually." Pet. App. 21. Thus, the court upheld the penalty assessed by the Secretary in this case, concluding that "[i]f states are permitted to rely on a facility's census, a facility providing inappropriate care will be encouraged simply not to list those patients[,] * * * contrary to the underlying purposes of the Act." *Id.* at 22-23.

ARGUMENT

The reasoning, and perhaps the result, in this case conflict with the recent decision of the Third Circuit in *Pennsylvania Dep't of Public Welfare* v. *HHS*, 928 F.2d 1378, 1385 (1991). That conflict, however, is of limited significance. Recent statutory changes have substantially reduced the number of facilities covered by the inspection, penalty, and safe harbor provisions at issue in this case. It is uncertain whether the problem of failure by States to inspect patients—the problem that raises the legal issues here and in *Pennsylvania Dep't of Public Welfare*—will continue to recur with respect to the remaining covered facilities. Aside from this case, the *Pennsylvania* case, and one case currently pending in each of the Eighth and Eleventh Circuits, we are aware of no other case involving these issues currently pending at an administrative level or in the courts. Consequently, in the absence of further developments indicating that the issue in this case will continue to recur, we do not believe the conflict in the circuits to be of sufficient significance to warrant further review.

1. The court of appeals properly upheld the Secretary's denial of reimbursement to petitioner in this case. Congress mandated that the medical care of each and every Medicaid recipient in covered facilities be reviewed annually. See 42 U.S.C. 1396a (a)(26) and (31), 1396b(g)(1). In light of this statutory mandate, the Secretary reasonably interpreted the "good faith"/"due diligence" safe harbor as requiring successful inspection of each recipient's medical care but for "events beyond [the State's] control which it could not have reasonably anticipated." 42 C.F.R. 456.653(a)(3). As the court

below noted, "to permit a state to avoid the statutory penalty merely because it made a subjective good faith effort to conduct the required inspections would vitiate the clearly expressed congressional intent that the care received by each Medicaid recipient be reviewed annually." Pet. App. 21. The Secretary's interpretation of "good faith" and "due diligence" is reasonable and "not in conflict with the plain language of the statute," and is therefore entitled to deference. *K Mart Corp.* v. *Cartier, Inc.*, 486 U.S. 281, 292 (1988); *Chevron U.S.A. Inc.* v. *NRDC, Inc.*, 467 U.S. 837, 843-845 (1984).

Further, on the facts of this case, it was not "virtually impossible," as petitioner claims, for it to have identified the missed Medicaid recipients at the Spring Creek facility. Pet. 9. Indeed, the DAB specifically found that other information was available to petitioner that could have assisted "in accurately identifying all recipients for whom a review was due." See Pet. App. 51-52. Thus, with respect to the missed patients in the Spring Creek facility, petitioner did not exercise "good faith" and "due diligence" in conducting the required review. The court of appeals properly upheld the Secretary's disallowance of funding.

2. Although we believe the court of appeals correctly decided this case, there is a disagreement in the courts of appeals over the proper interpretation of the "good faith"/"due diligence" safe harbor contained in 42 U.S.C. 1396b(g)(4)(B). In this case, the Tenth Circuit upheld the Secretary's implementing regulation requiring full compliance "but for events beyond [the State's] control which it could not have reasonably anticipated." 42 C.F.R. 456.653

(a)(3).[6] The Third Circuit, however, has struck down the Secretary's regulation and adopted a different approach, holding that "the words of the statute require the consideration of both subjective and objective factors in evaluating a state's attempt to inspect facilities." *Pennsylvania Dep't of Public Welfare* v. *HHS*, 928 F.2d 1378, 1385 (1991).[7] Because the Third Circuit remanded the case for an application of its approach, it is uncertain whether application of the Third Circuit's holding will result in a different judgment from that which would have been reached had the approach adopted by the Secretary and affirmed by the Tenth Circuit been applied.

3. Despite the disagreement between the Third and Tenth Circuits, the issue presented in this case is of limited and uncertain continuing significance. We note, first, that it is not an issue reflecting disagreement about obligations to afford treatment to persons under the Medicaid program, but instead is an issue concerning the possibility of limited discrepancies in apportionment of the program's costs between state and federal agencies. And, as we ob-

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[6] The Secretary's interpretation has also been upheld by the United States District Court for the Northern District of Georgia. *Johnson* v. *Sullivan*, 758 F. Supp. 1496, 1501-1503 (1991), appeal pending *sub nom. Toal* v. *Sullivan*, No. 91-6823 (11th Cir.).

[7] Two district courts have struck down the Secretary's regulation as inconsistent with the statute and adopted a solely subjective test, concluding that Congress in the Medicaid Act "plainly directed the Secretary to employ a subjective standard that focuses [solely] on the State's good faith" in conducting the required review. *Delaware Division of Health & Social Services* v. *HHS*, 665 F. Supp. 1104, 1124 (D. Del. 1987); *Arkansas* v. *Sullivan*, No. LR-C-88-793 (E.D. Ark. Oct. 18, 1990), appeal pending, No. 90-3100EA (8th Cir.).

served above, the 1987 Omnibus Budget Reconciliation Act amended the Medicaid Act in two respects pertinent to the present controversy. First, the 1987 OBRA limited the applicability of the "good faith"/"due diligence" safe harbor to "intermediate care facilities for the mentally retarded" (ICFMRs) and mental hospitals. See Pub. L. No. 100-203, Tit. IV, § 4212(d)(1), 101 Stat. 1330-212. Second, in place of the instant provision, Congress substituted an individualized assessment and state certification process for skilled nursing facilities and intermediate care facilities no longer covered by the provisions at issue here. Pub. L. No. 100-203, Tit. IV, § 4202, 101 Stat. 1330-174 to 1330-179, codified at 42 U.S.C. 1396r(g). See H.R. Rep. No. 391, 100th Cong., 1st Sess. 465-470 (1987) description of new assessment and certification process). The amendments are effective for all services provided on or after October 1, 1990, Pub. L. No. 100-203, Tit. IV, § 4214(a) and (c), 101 Stat. 1330-219 to 1330-220, as amended by Pub. L. No. 100-360, Tit. IV, § 411(*l*)(10), 102 Stat. 806.

As petitioner recognizes (Pet. 9 n.1), the amendments limit the future impact of the circuit conflict over the construction of the "good faith"/"due diligence" safe harbor. We are informed that approximately 22,000 institutions nationwide were covered by the inspection, penalty, and safe harbor provisions prior to the statutory change. That number has now been reduced to approximately 6600 institutions, of which approximately 6000 are intermediate care facilities for the mentally retarded. Although there are some 151,000 patients in such facilities, approximately 60% of the facilities are quite small, with patient populations of 8 or fewer patients each, and the proportion of such small institutions has been rapidly increasing.

In light of those facts, it is uncertain whether the legal issue on which the Third and Tenth Circuits disagree will continue to arise in the future. The "good faith"/"due diligence" safe harbor, whose meaning is the subject of the disagreement, is invoked only when a State has failed to inspect a covered facility. Because of the reduced number of covered facilities and the generally small size of those that remain, the problem of missed inspections—which has never been particularly widespread—may cease to arise or may arise only in a very small number of cases. We are aware of no cases raising this issue now pending before the Departmental Appeals Board, nor are there any cases pending in the courts aside from this case, the *Commonwealth of Pennsylvania* case, and the two cases now pending in the Eighth and Eleventh Circuits, *Arkansas* v. *Sullivan*, No. 90-3100EA (8th Cir.), and *Toal* v. *Sullivan*, No. 91-8623 (11th Cir.).

Moreover, in both *Pennsylvania Dep't of Public Welfare* and this case, the State failed to complete its inspections because it used facility-provided lists to determine which patients must be inspected. See Pet. App. 17; *Pennsylvania Dep't of Public Welfare*, 928 F.2d at 1378; see also *Johnson* v. *Sullivan*, 758 F. Supp. 1496, 1502 (N.D. Ga. 1991) (missed inspection due to use of facility-provided list), appeal pending, No. 91-8623 (11th Cir.). The difficulties of using facility-provided lists thus have now been highlighted by both the Third and Tenth Circuit decisions. In addition, HHS has taken steps to inform the States that facility-provided lists may be unreliable.[8]

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[8] In a manual transmitted to state agencies administering the Medicaid program, HHS has instructed: "You are responsible for identifying recipients for review, therefore do

In light of those facts, it is doubtful that a State that failed to inspect a facility in the future because it relied on a facility-provided list could be found to have exercised "due diligence," regardless of how that term is interpreted.

Consequently, although we recognize that the Third and Tenth Circuits have adopted divergent approaches to the statute and the regulations adopted thereunder, the continuing significance of the issue on which the two circuits have disagreed is in doubt. Accordingly, we do not believe that the issue is of sufficient importance at this time to warrant further review by this Court. Should further developments indicate that the difference between the approaches adopted by the two circuits will have a continuing impact on future cases, review by this Court could then be sought.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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not rely on eligibility input from the facility." State Medicaid Manual, Pt. 9 (Utilization Control), Transmittal No. 4, § 9155 (Jan. 1988).

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UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; LOUIS W. SULLIVAN, M.D.; NORVAL SETTLE; ALEXANDER TEITZ; and JUDITH BALLARD, in official capacities,
Respondents.

REPLY TO RESPONDENTS' BRIEF IN OPPOSITION TO PETITION FOR CERTIORARI

ON PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
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No. 90-1964

IN THE SUPREME COURT OF THE UNITED STATES
October Term, 1991

THE COLORADO DEPARTMENT OF SOCIAL SERVICES,
Petitioner,
vs.

UNITED STATES DEPARTMENT OF HEALTH
AND HUMAN SERVICES;
LOUIS W. SULLIVAN, M.D.; NORVAL SETTLE;
ALEXANDER TEITZ; and JUDITH BALLARD,
in official capacities,
Respondents.

REPLY TO RESPONDENTS' BRIEF IN OPPOSITION TO PETITION FOR CERTIORARI

ON PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE TENTH CIRCUIT

ARGUMENT

A. The States Remain Subject to Disallowances for Missed Patients in Inspections of Care.

The Department of Health and Human Services ("HHS") concedes that the Federal Courts of Appeal have split on the issues presented by this case, but argue that the conflict is of limited significance. The conflict remains significant to the States, for if the conflict is not resolved, HHS will be free to continue taking substantial disallowances contrary to the intent of Congress.

The cases which created the conflict between the circuits for which review is sought here construe existing Federal regulations which implement the inspection of care ("IOC") process for certain long-term care facilities. 42 C.F.R. § 456.652 (1988). Since the initiation of the subject disallowances, Congress has substituted a sampling technique for the 100 percent inspection of patients in nursing facilities including those formerly known as intermediate care facilities ("ICFs") and skilled nursing facilities ("SNFs") (Act of Dec. 22, 1987, Pub. L. No. 100-203 1988 U.S. Code Cong. & Admin. News (101 Stat.) 1330-212, 213, applicable as provided by § 4214 of such Act). However, the subject regulations continue to apply to intermediate care facilities for the mentally retarded ("ICFs-MR") and institutions for mental diseases ("IMDs").

Many penalties have been taken by HHS against the States regarding "missed" inspections of patients in ICFs and SNFs, despite the States' "good faith and due diligence" and contrary to the direction expressed by Congress in 42 U.S.C. §1396b(g)(4)(B) (1985). As HHS now has lost its ability to take disallowances based on the failure to perform 100 percent review of those facilities, it may direct its attention to the facilities remaining subject to IOC requirements to access further disallowances, trivially characterized by HHS as "limited discrepancies in apportionment," to the benefit of the Federal government at the expense of the States.

As HHS states, HCFA has taken steps, through its many disallowances and its rather late-coming Transmittal No. 4, §9155, State Medicaid Manual, Pt. 9 (Utilization Control), not issued until January of 1988, to "inform" the States that they may not rely on facility-generated information to determine which Medicaid patients are in facilities subject to inspection of care. The States are aware of the possibility that at least one patient may be missed due to an unintentional error of the facility generating its census

list.[1] However, information from other sources has proved difficult to obtain and to be of questionable reliability. HHS has offered no realistic alternative method for verification. Even with the implementation of burdensome additional processes to gather patient information, Colorado continues to depend primarily on the facility's census. Therefore, the potential for future disallowances continues.

Although HHS argues that the IOC inspection requirements are no longer significant, its actions speak otherwise. The District Court in *Arkansas v. Sullivan,* No. LR-C-88-793 (E.D. Ark., Oct. 18, 1990) rendered its decision (Appendix "A") reversing a disallowance taken for Arkansas' failure to review one patient in an ICF, on October 18, 1990, *after* the effective date of the subject statutory amendment. Nevertheless, HHS appealed that decision which now is pending in *Arkansas v. Sullivan*, No. 90-3100 EA (8th Cir.).

For years, the States have suffered disallowances of substantial sums of money at the hands of HHS due to the Agency's refusal to give the States the benefit of the exceptions Congress granted to them. Only now have the States' appeals advanced to this level of review. The Federal Government should not be allowed to continue taking unlawful disallowances in some jurisdictions just because it may not be able to take as many of them now as it has taken in the past.

---

[1]HHS has presented no evidence that any facilities have intentionally omitted patients from review or that any patients omitted from facility census lists have been subject to abuse or neglect.

B. Disallowances Taken Against Colorado Would be Reversed or Remanded by this Court's Determination that the Subject Regulations are Unreasonable.

HHS contends that even had the Court of Appeals for the Tenth Circuit found the HHS "safe harbor" regulations unreasonable by adopting the approach taken by the District Court in *Delaware Division of Health and Social Services v. Department of Health and Human Services*, 665 F. Supp. 1104 (D. Del. 1987) and by the Third Circuit in *Pennsylvania Department of Public Welfare v. Department of Health and Human Services*, 928 F.2d 1378 (3d Cir. 1991), Colorado would not meet even the subjective standard expressed by those courts. This contention cannot be supported by the record in this case.

Even had Colorado utilized Peer Review Organization eligibility information as suggested by the Departmental Appeals Board ("DAB"), only two of the three omitted patients would have been reviewed. By the regulations at issue here, missing even one patient would subject the State to the same penalties as though it had failed to inspect the facility altogether. Had other Medicaid billing information been used for verification, its untimeliness would not have avoided the disallowance.

The proceedings before the DAB were conducted only pursuant to the existing regulations of HHS. The DAB, in its quasi-adjudicative function, must follow regulations promulgated in its quasi-legislative function. *Arizona Grocery Co. v. Atchison, Topeka, & Santa Fe Railway Co.*, 284 U.S. 370 (1931). Therefore, Colorado did not present argument and evidence to the DAB to meet the requirements of alternative regulations which were beyond the authority of the DAB to adopt. Upon review of this Court, if any question remains whether Colorado meets the exception under the proper statutory interpretation, the case

should be remanded back to the DAB as was done in *Pennsylvania Department of Public Welfare v. Department of Health and Human Services, supra*.

CONCLUSION

The Petition for Certiorari should be granted.

Respectfully submitted,

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APPENDIX A

IN THE UNITED STATES DISTRICT
EASTERN DISTRICT OF ARKANSAS
WESTERN DIVISION

STATE OF ARKANSAS, BY ITS
DIRECTOR OF THE DEPARTMENT OF
HUMAN SERVICES, DR. TERRY
YAMAUCHI PLAINTIFF

v. Civil No. LR-C-88-793

LOUIS M. SULLIVAN, M.D.,
IN HIS OFFICIAL CAPACITY AS
SECRETARY OF THE DEPARTMENT OF
HEALTH AND HUMAN SERVICES, and
THE UNITED STATES DEPARTMENT OF
HEALTH AND HUMAN SERVICES DEFENDANTS

JUDGMENT

In accordance with the Memorandum Opinion and Order entered this date, judgment is entered in favor of plaintiff and against defendants. Defendants' disallowance is arbitrary, capricious and contrary to law. Defendants are permanently enjoined from taking any steps to recover disallowed funds from the State paid under the Medicaid program for payment of services in ICF facilities for the period ending June 30, 1987.

IT IS SO ORDERED this 18 day of October, 1990.

_____
GEORGE HOWARD, JR.
UNITED STATES DISTRICT JUDGE

IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF ARKANSAS
WESTERN DIVISION

STATE OF ARKANSAS, BY ITS
DIRECTOR OF THE DEPARTMENT OF
HUMAN SERVICES, DR. TERRY
YAMAUCHI PLAINTIFF

v. Civil No. LR-C-88-793

LOUIS M. SULLIVAN, M.D.,
IN HIS OFFICIAL CAPACITY AS
SECRETARY OF THE DEPARTMENT OF
HEALTH AND HUMAN SERVICES, and
THE UNITED STATES DEPARTMENT OF
HEALTH AND HUMAN SERVICES DEFENDANTS

MEMORANDUM OPINION AND ORDER

The State of Arkansas brings this action challenging the determination by the Department of Health and Human Services ("HHS") disallowing federal funding claimed by Arkansas under the Medicaid program of the Social Security Act ("Act") for the quarter ending June 30, 1987. The disallowance is based on the failure of Arkansas to timely review one patient in an intermediate care facility ("ICF"). This Court has jurisdiction pursuant to 5 U.S.C. §701 et seq. *See Bowen v. Massachusetts*, 108 S.Ct. 2722 (1988).

FACTS

"The Medicaid program was created in 1965, when Congress added Title XIX to the Social Security Act ... for the purpose of providing federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons." *Harris v. McRae*, 448 U.S. 297, 301 (1980). In exchange for federal Medicaid payments, each participating state must submit a "state plan" which meets certain conditions specified in the Act.

At issue in this case are the requirements that each state conduct periodic inspections of ICFs and that the state have an effective program of review of medical care of patients.

On March 31, 1988, the Health Care Financing Administration ("HCFA") of HHS notified the Arkansas Department of Human Services ("State" or "Arkansas") that HCFA was reducing federal financial participation ("FFP") for amounts Arkansas claimed for ICF services under the Medicaid program. The disallowance, originally amounting to $212,614.00, was made pursuant to HHS' determination that the State had failed to make a satisfactory and valid showing that there was in operation an effective program for medical review of the care of ICF patients for the calendar quarters ending June 30, September 30, and December 31, 1987. HHS concluded that the State's showing was unsatisfactory due to the State's alleged failure to review the quality of care of one patient for one quarter in one ICF, and one patient for three quarters in another ICF.

During the course of the appeal to the Departmental Appeals Board ("DAB"), HCFA withdrew the disallowance at one facility for the September 30 and December 31 quarters. Thus, the DAB considered the disallowances involving two ICF residents residing in different facilities for the June 30, 1987 quarter.

The DAB issued its decision on October 17, 1988. It reversed the disallowance as to one resident at Crestpark, an ICF, finding that the failure to conduct a medical review on that patient was not the State's fault. In particular, the State had designated the patient for review but the administrator of the facility had mistakenly informed the State inspection team that the resident had been transferred and was no longer in the facility. Although the transfer documents for the patient had been completed, the patient did not actually leave the facility until the day after the inspection. The DAB found that "the failure to review the patient did not result from a systemic flaw in the State's patient identification process." DAB Decision 992, p. 5. The DAB reversed HCFA's finding of a deficient review at Crestpark.

At Nashville, another ICF, the State conceded that one patient was not reviewed. The State attributed the failure to conduct a timely review to "human error," i.e., the State could not offer any particular explanation for its failure to review the patient.[2]

The DAB found that Arkansas' explanation was in essence no explanation and therefore it could not invoke a statutory exception to the annual review requirement. Thus, the DAB sustained the disallowance for Nashville.

The DAB directed the parties to establish the reduced amount of the disallowance. If they could not agree upon an amount, the DAB would determine it.

Arkansas appealed the decision. Arkansas argues that HCFA seeks to recover $62,067.00 for Arkansas' failure to review one patient in one facility.

---

[2]This patient, however, was ultimately reviewed in late September, 1987.

APPLICABLE STATUTES AND REGULATIONS

Pursuant to 42 U.S.C. §1396b(g)(1)(D), in any calendar quarter for which a state submits a request for payment for ICF services furnished, the state must make a "showing satisfactory to the Secretary" that it has "an effective program of medical review of the care of patients" in ICFs "whereby the professional management of each case is reviewed and evaluated at least annually by independent professional review teams."

A state Medicaid plan must provide with respect to each ICF within the state

> (B) . . . for periodic inspections of the care of each person receiving medical assistance, by one or more independent professional review teams . . . , including with respect to each such person (i) the adequacy of the services available to meet his current health needs and promote his maximum physical well-being, (ii) the necessity and desirability of his continued placement in the facility, and (iii) the feasibility of meeting his health care needs through alternative institutional or noninstitutional services . . .

42 U.S.C. §1396a(a)(31)(B).

Unless a state makes a satisfactory showing of an effective utilization program as required by section 1396b(g)(1) and 1396a(a)(31), the total amount of federal Medicaid reimbursement to the state is reduced according to a statutory formula. 42 U.S.C. §1396b(g)(5).

Section 1396b(g)(4)(B) provides a statutory exception to

the annual review requirement. Thus, according to the statute, the Secretary shall find a showing to be satisfactory

> (B) . . . if the showing demonstrates that the State has conducted such an onsite inspection during the 12-month period ending on the last date of the calendar quarter --
>
> (i) in each of not less than 98 per centum of the number of such hospitals and facilities requiring such inspection, and
>
> (ii) in every such hospital or facility which has 200 or more beds,
>
> and that, with respect to such hospitals and facilities not inspected within such period, the State has exercised good faith and due diligence in attempting to conduct such inspection, or if the State demonstrates to the satisfaction of the Secretary that it would have made such a showing but for failings of a technical nature only.

HHS promulgated regulations implementing the statutory provision. Pursuant to 42 C.F.R. §456.653, an agency's showing will be satisfactory, even if it failed to meet the annual review requirements, if

> (a) the Agency demonstrates that --
>
> (1) It completed reviews by the end of the quarter in at least 98 percent of all facilities requiring review by the end of the quarter;
> (2) It completed reviews by the end of the quarter in all facilities with 200 or more

certified Medicaid beds requiring review by the end of the quarter; and

(3) With respect to all unreviewed facilities, the agency exercised good faith and due diligence by attempting to review those facilities and would have succeeded but for events beyond its control which it could not have reasonably anticipated; or

(b) The agency demonstrates that it failed to meet the standard in paragraph (a)(l) and (2) of this section by the close of the quarter for technical reasons, but met the standard within 30 days after the close of the quarter. Technical reasons are circumstances within the agency's control.

STANDARD AND SCOPE OF JUDICIAL REVIEW

A reviewing court shall set aside an agency's action which is arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law. 5 U.S.C. §706(2)(A); *Citizens to Preserve Overton Park, Inc. v. Volpe*, 401 U.S. 402, 416 (1971). In general, courts afford deference to an agency's construction and interpretation of the statute. A court's deference is not absolute, however. A court will invalidate as contrary to law regulations which are found to deviate from Congressional will. *Cambridge Hospital Association v. Bowen*, 655 F.Supp. 439, 441 (D. Minn. 1987). Furthermore, a "court need not accept an agency's interpretation of its own regulations if that interpretation is inconsistent with the statute under which the regulations were promulgated, is plainly inconsistent with the wording of the regulation, or otherwise deprives affected parties of fair notice of the agency's intentions." *Oglala Sioux Tribe of Indians v. Andrus*, 603 F.2d 707, 718 (8th Cir. 1979).

ANALYSIS

Arkansas relies on the court's holding in *Delaware Division of Health and Social Services v. U.S. Department of Health and Human Services*, 665 F.Supp. 1104 (D. Del. 1987) to support its argument that HHS' action must be reversed. In *Delaware*, the state had failed to review four patients in two facilities. The state asserted that the patients had not been reviewed because "'[f]or some unknown reason their names had been deleted inadvertently from the regional Medicaid list'". **Id.** at 1114. The Review Board upheld HHS' decision to disallow Medicaid funding for the two facilities for two quarters of 1984.

The court reversed HHS' disallowance. The court found that HHS' regulations interpreting the statutory language that state agencies "conduct" on-site inspections to mean "complete" reviews were arbitrary and capricious. It further found that HHS' regulation defining "good faith and due diligence" was arbitrary and capricious as it is more restrictive than the standards provided for in the Act and in conflict with the language of the statute.

The *Delaware* court also found that the Secretary's interpretation of the regulations and statute--including the "good faith" and "technical failing" exceptions--were arbitrary and capricious.

HHS argues that the reasoning in *Delaware* is flawed, that the statute requires that review of each patient in each facility is a requirement, and that the reviews be completed, not merely conducted.

The Court need not decide the issue of whether the regulation requiring the review be completed conflicts with the statutory mandate that annual reviews be conducted on each patient. The Court agrees with the decision in *Delaware* that the regulation interpreting good faith and due diligence is inconsistent

with the congressional purpose and unreasonably restrictive.

The Good Faith Exception

The regulations interpret "good faith and due diligence" to mean "circumstances beyond the agency's control." 42 C.F.R. §456.653. The HCFA's commentary accompanying the regulation states: "We believe that the inherent meaning of the phrase 'good faith and due diligence' is that the State agency made attempts to perform reviews but was prevented from doing so by circumstances over which it had no control." As examples of such circumstances preventing review, HCFA lists inclement weather or a quarantine of the facility. 44 F.R. 56336.

The legislative history surrounding the "good faith" exception reveals that Congress did not intend as limiting an exception as that contained in the regulations. The Conference agreement rejected the harsh language of the Senate amendment which would have provided that the Secretary could waive any reduction in Medicaid payment if the Secretary determines that the State's noncompliance is technical or due to circumstances beyond control of the State. Rather, the conferees agreed on a subjective standard, that is that the state make good faith attempts to perform reviews of all institutions, and actually review all large institutions and 98 percent of all other institutions. "If a facility is not reviewed, there will be a reduction in matching unless the Secretary finds there was a good faith attempt to review the institution, and there is no evidence that any institution, or kind or type of institution, is deliberately not reviewed." H.Rep. No. 95-673, 95th Cong., 1st Sess. 48 (1977), reported in U.S. Code Cong. & Admin. News 1977, pp. 3039, 3122.

Thus, the Conference agreement explicitly rejected the language the Secretary added to the regulations for the good faith" exception. The Secretary's requirement of demonstrating circumstances beyond the control of the agency is clearly more

demanding than that desired by Congress, i.e., that the state make a "good faith attempt" at 100 percent review, and that failure to do so not be deliberate.

"The Social Security Act, because of its remedial purposes, must be broadly construed to favor the intended beneficiaries of the Medicaid program." 665 F.Supp. at 1122. Thus, while Congress is concerned with the adequacy of care provided patients in long-term care facilities, the need to provide adequate funding for patient care cannot rest on hypertechnical, inflexible requirements. Thus, the Court is persuaded that Congress intended that states be allowed some level of tolerance for **de minimis** errors, where such errors are not deliberate or systemic.

The Court finds that the Secretary's regulation defining the "good faith and due diligence" is inconsistent with the purposes and policies embodied in the statute, and is more restrictive than the statutory mandate. As such, the regulation is contrary to law and must be set aside. *See Pacific Coast Medical Enterprises v. Harris*, 633 F.2d 123, 131 (9th Cir. 1980).

The Court also finds that the DAB's finding that Arkansas had not exercised good faith and due diligence is arbitrary and capricious. The Court notes that Arkansas had reviewed all patients in all facilities, save one. Certainly, this near 100 percent compliance falls within the legislative mandate that the State made a good faith attempt to review the institution, and its failure to timely review one patient was inadvertent.

CONCLUSION

The Court finds that HHS' disallowance is arbitrary, capricious, and contrary to law. In particular, the Court finds that the regulation interpreting "good faith and due diligence" is void and the Board's interpretation of that regulation is arbitrary and

capricious. The. decision of the DAB is reversed. HHS is permanently enjoined from taking any steps to recover disallowed funds from the State paid under the Medicaid program for payment of services in ICF facilities for the period ending June 30, 1987.

IT IS SO ORDERED this 18 day of October, 1990.

_____

GEORGE HOWARD, JR.
UNITED STATES DISTRICT JUDGE